STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G466	A. BUILDING 00 B. WING	10/08/2012

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REM-INDIANA INC	1926 W 75TH PL INDIANAPOLIS, IN 46260

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W0000	This visit was for a predetermined full annual recertification and state licensure survey. This visit was done in conjunction with the PCR (Post Certification Revisit) for the investigation of complaint #IN00112797 completed on 8/24/12. Dates of Survey: 10/1/12, 10/2/12, 10/3/12 and 10/8/12. Facility Number: 000980 Provider Number: 15G466 AIMS Number: 100244620 Surveyor: Keith Briner, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed October 15, 2012 by Dotty Walton, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 3 of 3 sampled clients (A, B and C) plus three additional clients (D, E and F), the governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure clients A and B's finances were not in excess of predetermined maximum amounts allowed by Medicaid. The governing body failed to exercise general policy, budgeting and operating direction over the facility to assure a full and complete accounting of client's A, B ,C, D, E, and F's finances and failed to reimburse missing funds (clients D, E, and F). The governing body failed to exercise general policy, budgeting and operating direction over the facility by failing to ensure their nursing services provided clients B and C with necessary adaptive equipment and training/methodologies in their program plans. Findings include: 1. Client A's financial record was reviewed on 10/2/12 at 11:48 AM. Client A's facility based cluster account ledger, kept by administrative staff in the agency office, dated 8/20/12 through 10/2/12	W0104	1. The Home Manager and Program Director will complete an audit of all consumers finances, to determine if anyone's account balance is in excess of the allowable amount. If any consumers account balances are in excess of the allowable amount the Home Manager and Program Director will work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount. 2. The Home Manager and Program Director will complete an audit of all consumers finances to ensure that petty cash ledgers are updated and maintained for all clients. 3. Paperwork has been completed for Client D, E and F to get reimburse for missing funds. Area Director will follow up with Accounting Department to check on the status of consumers getting reimbursed for missing money. The Home Manager and Program Director will receive retraining on consumers finances including ensuring that all consumers	11/07/2012

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	indicated the following: -8/20/12, RBW (Room and Board Withdrawal), $28.00 with an ending balance in the amount of $5,358.04 -8/20/12, RBW, $28.00 with an ending balance in the amount of $5,330.04 -9/11/12, RBW, $28.00 with an ending balance in the amount of $5,302.04 Client B's financial record was reviewed on 10/2/12 at 11:48 AM. Client B's facility based cluster account ledger dated 7/17/12 through 10/2/12 indicated the following: -7/17/12, SSD (Social Security Deposit), $6,187.00 with an ending balance in the amount of $9,361.54 -7/17/12, SSD, $465.00 with an ending balance in the amount of $9,826.54 -7/17/12, RBW, $1,089.00 with an ending balance in the amount of $8,737.54 -8/3/12, SSD, $93.00 with an ending balance in the amount of $8,830.54 -8/3/12, SSD, $1,239.00 with an ending balance in the amount of $10,069.54		accounts are below the allowable amount and that Petty cash ledgers are up to date and are maintained monthly for all consumers financial transactions. Ongoing the Client Finance Specialist will provide a record monthly to the Area Director of all consumers that have an account balance in excess of the allowable amount. The Area Director will ensure that the Program Director and Home Manager are notified so the can work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount. Ongoing, the Home manager will review the clients finances a minimum of weekly to ensure that Petty cash ledgers are up to date. The Program Director will review and reconcile the finances a minimum of monthly to ensure that all records are up to date and accurate. Responsible Party: Home Manager, Program Director, Area Director, Client Finance Specialist	

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	-8/20/12, RBW, $1,089.00 with an ending balance in the amount of $8,980.54 -8/31/12, SSD, $93.00 with an ending balance in the amount of $9,073.54 -8/31/12, SSD, $1,239.00 with an ending balance in the amount of $10,312.54 -9/11/12, RBW, $1,089.00 with an ending balance in the amount of $9,223.54 2. Client A's financial record was reviewed on 10/2/12 at 11:48 AM. Client A's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review. Client B's financial record was reviewed on 10/2/12 at 11:49 AM. Client B's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review. Client C's financial record was reviewed on 10/2/12 at 11:50 AM. Client C's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review. 3. The facility's BDDS (Bureau of			

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	Developmental Disabilities Services) reports and investigations were reviewed on 10/2/12 at 8:50 AM. The review indicated the following: -BDDS report dated 9/11/12 indicated, "Money was given to staff on the evening of 9/7/12 and put in a lock box. Later that evening staff took some of the consumers to the gas station. The next morning when staff went to take the consumers out [client D] was missing $5.00..., [client E] was missing $5.00 and [client F] was missing $5.00." AS (Administrative Staff) #1 was interviewed on 10/2/12 at 11:48 AM. AS #1 indicated the maximum allowable amount was $1,500.00. AS #1 indicated the account balances for client A and client B were in excess of the allowable amount. AS #1 indicated client's D, E and F had not been reimbursed their missing money. AS #1 indicated the clients' needed to be reimbursed the missing money. AS #1 stated, "We do not have a full accounting of funds (clients' cash kept in the group home). We switched home managers, it was a mess... not accounted for. We have been in the process of reconciling funds and ledgers." The governing body failed to exercise general policy, budgeting and operating			

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	direction over the facility by failing to ensure their nursing services provided clients B and C with necessary adaptive equipment and training/methodologies in their program plans. Please see W331. 9-3-1(a)			

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W0125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure the clients' rights were not violated by restricting their access to knives without due process through assessment of individual need. Findings include: Observations were conducted at the group home on 10/1/12 from 4:51 PM through 6:00 PM. At 5:10 PM staff #1 was assisting clients with the evening meal preparation in the group home kitchen. Staff #1 exited the kitchen and entered the group home living room area where the medication cabinet was located. Staff #1 approached the medication administration area where staff #2 was preparing medication for administration and stated, "I need a knife" and removed a knife from the medication cabinet. At 5:45 PM staff #1 washed the knife at the kitchen sink and returned the knife to the medication administration cabinet.	W0125	The Program Director will review the need for all consumers regarding restricted access to the knives in the home. If it is determined that any consumers need restricted access, the Program Director will ensure that the restriction is put into the consumers Behavior Support Plan and guardian and Human Rights Committee Approval is obtained. For other consumers that do not require restricted access to the knives in the home, the Home Manager and Program Director will develop a way for them to have access to the knives as needed such as having a key to where the knives are locked up. The Home Manager and Program Director will receive retraining on not violating consumers rights by restricting access to the knives in the home with out due process through assessment of individual need. Ongoing, the Home Manager and Program Director will ensure that all consumers rights are not violated by restricting access to	11/07/2012

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	Client A's record was reviewed on 10/2/12 at 12:14 PM. Client A's ISP (Individual Support Plan) dated 8/11/11 did not indicate client A needed or required to be restricted from access and/or use of knives. Client A's record did not indicate a BSP (Behavior Support Plan). Client A's CFA (Comprehensive Functional Assessment) dated 7/27/09 did not indicate the need for restricted access to knives. Client A's record did not indicate HRC (Human Rights Committee) approval for access to knives to be restricted. Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's ISP dated 3/23/12 did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's BSP dated 6/30/12 did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's undated CFA did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's record did not indicate HRC approval for access to knives to be restricted. Client C's record was reviewed on 10/2/12 at 1:09 PM. Client C's ISP dated 2/7/12 did not indicate client C needed to be restricted from access to and/or the use of knives. Client C's BSP dated 9/1/12		anything unless determined by the IDT and approval obtained from guardian (if needed) and Human Rights Committee. Responsible Parties: Home Manager, Program Director	

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	did not indicate client C needed to be restricted from access to and/or the use of knives. Client C's CFA dated 4/22/12 did not indicate client C needed to be restricted from access to and/or the use of knives. Client C's record did not indicate HRC approval for access to knives to be restricted. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated the group home locked the knives in the medication cabinet. QMRP #1 indicated clients A, B and C did not have product misuse or history of misuse/threat of use of knives as weapons. QMRP #1 indicated client A, B and C did not have a key to access the knives in the house. 9-3-2(a)			

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W0140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 3 sampled clients (A, B and C) plus 3 additional clients (D, E and F), the facility failed to ensure a full and complete accounting of clients' finances and failed to reimburse missing funds. Findings include: 1. Client A's financial record was reviewed on 10/2/12 at 11:48 AM. Client A's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review. 2. Client B's financial record was reviewed on 10/2/12 at 11:49 AM. Client B's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review. 3. Client C's financial record was reviewed on 10/2/12 at 11:50 AM. Client C's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review.	W0140	1. The Home Manager and Program Director will complete an audit of all consumers finances, to determine if anyone's account balance is in excess of the allowable amount. If any consumers account balances are in excess of the allowable amount the Home Manager and Program Director will work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount. 2. The Home Manager and Program Director will complete an audit of all consumers finances to ensure that petty cash ledgers are updated and maintained for all clients. 3. Paperwork has been completed for Client D, E and F to get reimburse for missing funds. Area Director will follow up with Accounting Department to check on the status of consumers getting reimbursed for missing money. The Home Manager and Program Director will receive retraining on consumers finances including ensuring that all consumers	11/07/2012

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	4. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/2/12 at 8:50 AM. The review indicated the following: -BDDS report dated 9/11/12 indicated, "Money was given to staff on the evening of 9/7/12 and put in a lock box. Later that evening staff took some of the consumers to the gas station. The next morning when staff went to take the consumers out [client D] was missing $5.00..., [client E] was missing $5.00 and [client F] was missing $5.00." AS (Administrative Staff) #1 was interviewed on 10/2/12 at 11:48 AM. AS #1 indicated client's D, E and F had not been reimbursed their missing money. AS #1 indicated the clients' needed to be reimbursed the missing money. AS #1 stated, "We do not have a full accounting of funds (group home cash accounts for clients A, B, and C). We switched home managers, it was a mess... not accounted for. We have been in the process of reconciling funds and ledgers." 9-3-2(a)		accounts are below the allowable amount and that Petty cash ledgers are up to date and are maintained monthly for all consumers financial transactions. Ongoing the Client Finance Specialist will provide a record monthly to the Area Director of all consumers that have an account balance in excess of the allowable amount. The Area Director will ensure that the Program Director and Home Manager are notified so the can work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount. Ongoing, the Home manager will review the clients finances a minimum of weekly to ensure that Petty cash ledgers are up to date. The Program Director will review and reconcile the finances a minimum of monthly to ensure that all records are up to date and accurate. Responsible Party: Home Manager, Program Director, Area Director, Client Finance Specialist	

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 17 allegations of abuse, mistreatment or neglect reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an incident of medication omission regarding client B. The facility failed to immediately notify BDDS in accordance with state law regarding an incident of clients D, E and F's missing petty cash. Findings include: The facility's BDDS reports and investigations were reviewed on 10/2/12 at 8:50 AM. The review indicated the following: -BDDS follow up report dated 8/31/12 indicated, "[client B] missed the following medications: Oyster Shell Calcium with Vitamin D 500 milligrams (supplement) and Risperidone 1 milligram (impulse control)." The BDDS report indicated, "The on call nurse was contacted by staff, [staff #1], on 8/24/12	W0153	All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director	11/07/2012

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	at 5:15 PM regarding the medication error. [Staff #1] noticed the error (medication was still in the cabinet but [staff #2] had signed off that the medication was given). On-call nurse informed the house nurse on 8/27/12. This home is in between home managers and although one home manager is helping cover the home the 6 day difference is due to a miscommunication. Program director was not made aware of the error and able to get clarification until 8/29/12 and made the report right away." -BDDS report dated 9/11/12 indicated, "Money was given to staff on the evening of 9/7/12 and put in a lock box. Later that evening staff took some of the consumers to the gas station. The next morning when staff went to take the consumers out [client D] was missing $5.00..., [client E] was missing $5.00 and [client F] was missing $5.00." Interview with AS (Administrative Staff) #2 on 10/2/12 at 11:14 AM indicated BDDS reportable incidents included medication omissions and clients' missing petty cash funds. AS #2 indicated BDDS reportable incidents should be reported to BDDS within 24 hours of the incident. 9-3-1(b)(5) 9-3-2(a)		within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. Responsible Party: Home Manager, Program Director, Area Director	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	1926 W 75TH PL INDIANAPOLIS, IN 46260

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the QMRP (Qualified Mental Retardation Professional) failed to ensure facility staff implemented clients B and C's training objectives during formal and informal training opportunities. The QMRP failed to ensure clients A and B CFA's (Comprehensive Functional Assessment) were reviewed annually. The QMRP failed to ensure client A's ISP (Individual Support Plan) was reviewed annually. The QMRP failed to coordinate client B's programs to ensure the facility obtained written informed consent from client B's legal representative prior to a restrictive program. The QMRP failed to coordinate clients A, B and C's programs to ensure the clients' rights were not violated by the restriction of locking knives without due process through assessment of individual need. Findings include: 1. The QMRP failed to ensure facility staff implemented clients B and C's training objectives during formal and informal training opportunities. Please see	W0159	1. All Direct Care staff will receive retraining on all consumers Medication Administration goals and the need to complete formal training goals as indicated, especially at Medication administration times. For the next four weeks, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of twice weekly to ensure that all staff are completing all consumers Medication Administration goals as written. Ongoing, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of once weekly to ensure that all staff are completing all consumers Medication Administration goals as written. 2. Comprehensive Functional Assessments for all consumers will be completed and placed in the consumers file. The Program Director will receive retraining on ensuring that all consumers have Comprehensive Functional Assessments completed annually in accordance with the annual Individual Support plan. For the next 3 months, the Area Director	11/07/2012

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	W249. 2. The QMRP failed to ensure clients A and B CFA's were reviewed annually. Please see W259. 3. The QMRP failed to ensure client A's ISP was reviewed annually. Please see W260. 4. The QMRP failed to coordinate client B's programs to ensure the facility obtained written informed consent from client B's legal representative prior to implementing a restrictive program. Please see W263. 5. The QMRP failed to coordinate clients A, B and C's programs to ensure the clients' rights were not violated by the restriction of locking knives without due process through assessment of individual need. Please see W264. 9-3-3(a)		will review all ISPs written by this Program Director to ensure that Comprehensive Functional Assessments are being completed and the data collected is being utilized in the development of training goals and objectives. 3. Program Director will update and complete Client A's ISP. The Program Director will review all other consumers ISP dates and ensure that any others that are not up to date are completed as soon as possible. The Program Director will receive retraining on the need to ensure that all consumers ISPs are completed annually before the expiration date. For the next 3 months, the Area Director will review all ISPs written by this Program Director to ensure that ISPs are being completed annually before the expiration date. 4. The Program Director will receive retraining on ensuring that consumers' guardians or Health Care Representatives are notified of any additions or changes to consumers' psychotropic medications and any additions or changes to consumers Behavior Support plans. The Program Director will also receive retraining on ensuring that consumers' guardians and/or Health Care Representatives review and approve any changes or updates to psychotropic medications	

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			and/or Behavior Support plans prior to their implementation. For the next 3 months, the Program Director will provide documentation to the Area Director that consumers' guardians or Health Care Representatives have received notification of any changes to psychotropic medications and Behavior Support Plans and have approved any changes. After the 3 month period, the Area Director will review the documentation that guardians or Health Care Representatives are receiving updated copies of consumers BSPs a minimum of quarterly to ensure that these requirements continue to be met. 5. The Program Director will review the need for all consumers regarding restricted access to the knives in the home. If it is determined that any consumers need restricted access, the Program Director will ensure that the restriction is put into the consumers Behavior Support Plan and guardian and Human Rights Committee Approval is obtained. For other consumers that do not require restricted access to the knives in the home, the Home Manager and Program Director will develop a way for them to have access to the knives as needed such as having a key to where the knives are locked up. The Program Director will receive retraining on the need to ensure	

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			that Human Rights Committee Approvals are obtained for any restrictions recommended for any consumer prior to the restrictions being implemented. Ongoing, the Program Director will ensure that Human Rights Committee Approvals are obtained for any restrictions recommended for any consumer prior to the restrictions being implemented. Responsible Party: Home Manager, Program Director, Area Director	

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 2 of 3 sampled clients (B and C), the facility failed to implement the clients B and C training objectives during formal and informal training opportunities. Findings include: Observations were conducted at the group home on 10/2/12 from 6:00 AM through 8:00 AM. At 7:11 AM client B was prompted by staff #3 to come to the medication administration area. Client B came to the medication administration area and sat down. Staff #3 proceeded to administer client B's morning medications. Staff #3 did not prompt or encourage client B to participate in the administration of her medication. At 7:29 AM client C was prompted by staff #3 to come to the medication administration area. Client C came to the medication administration area and sat down. Staff #3 proceeded to administer client C's morning medications. Staff #3 did not	W0249	All Direct Care staff will receive retraining on all consumers Medication Administration goals and the need to complete formal training goals as indicated, especially at Medication administration times. For the next four weeks, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of twice weekly to ensure that all staff are completing all consumers Medication Administration goals as written. Ongoing, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of once weekly to ensure that all staff are completing all consumers Medication Administration goals as written. Responsible Staff: Home Manager, Program Director	11/07/2012

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	prompt or encourage client C to participate in the administration of her medication. Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's ISP (Individual Support Plan) dated 3/23/12 indicated client B was not independent in medication administration and required additional training and supports. Client B's ISP indicated, "Daily, [client B] will state the name of a medication, the dosage, the color, the shape and one side effect with one verbal prompt or less 75% of the time for three consecutive months." Client C's record was reviewed on 10/2/12 at 1:09 PM. Client C's ISP dated 2/7/12 indicated client C was not independent in medication administration and required additional training and supports. Client C's ISP indicated, "Twice daily, [client C] will state what she is taking her medication for with two verbal prompts or less." Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated the staff should train clients at every available opportunity. QMRP #1 indicated formal and informal training should be occurring during medication administration times.			

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W0259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 sampled clients (A and B), the facility failed to ensure clients A and B CFA's (Comprehensive Functional Assessments) were reviewed annually. Findings include: 1. Client A's record was reviewed on 10/2/12 at 12:14 PM. Client A's CFA dated 7/27/09 did not indicate the assessment had been reviewed annually. 2. Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's CFA was undated. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated client A's CFA should be updated annually. QMRP #1 indicated client B's CFA was undated and had not been updated at the time of her annual ISP (Individual Support Plan) dated 3/23/12. 9-3-4(a)	W0259	Comprehensive Functional Assessments for all consumers will be completed and placed in the consumers file. The Program Director will receive retraining on ensuring that all consumers have Comprehensive Functional Assessments completed annually in accordance with the annual Individual Support plan. For the next 3 months, the Area Director will review all ISPs written by this Program Director to ensure that Comprehensive Functional Assessments are being completed and the data collected is being utilized in the development of training goals and objectives. Responsible Party: Program Director, Area Director.	11/07/2012

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W0260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's ISP (Individual Support Plan) was revised annually. Findings include: Client A's record was reviewed on 10/2/12 at 12:14 PM. Client A's ISP (Individual Support Plan) was dated 8/11/11. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated client A did not have a more current ISP for review. QMRP #1 indicated client A's ISP should be updated annually. 9-3-4(a)	W0260	The Program Director will update and complete Client A's ISP. The Program Director will review all other consumers ISP dates and ensure that any others that are not up to date are completed as soon as possible. The Program Director will receive retraining on the need to ensure that all consumers ISPs are completed annually before the expiration date. For the next 3 months, the Area Director will review all ISPs written by this Program Director to ensure that ISPs are being completed annually before the expiration date. Responsible Party: Program Director, Area Director	11/07/2012

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W0263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 3 sampled clients (B) with psychotropic behavior control medications, the facility failed to obtain written informed consent from the client B's legal representative prior to the implementation of a restrictive program. Findings include: Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's ISP dated 3/23/12 indicated client B's sister was her guardian. Client B's BSP (Behavior Support Plan) dated 6/30/12 indicated the use of Fluoxetine capsule 40 milligrams (impulse control), Risperidone 1 milligram (behavior control) and Lithium Carbonate capsule 300 milligrams (impulse control). Client B's BSP was not signed/approved by the client or the client's sister/guardian. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated client B's guardian should have given written informed consent and approved the BSP prior to	W0263	The Program Director will receive retraining on ensuring that consumers' guardians or Health Care Representatives are notified of any additions or changes to consumers' psychotropic medications and any additions or changes to consumers Behavior Support plans. The Program Director will also receive retraining on ensuring that consumers' guardians and/or Health Care Representatives review and approve any changes or updates to psychotropic medications and/or Behavior Support plans prior to their implementation. For the next 3 months, the Program Director will provide documentation to the Area Director that consumers' guardians or Health Care Representatives have received notification of any changes to psychotropic medications and Behavior Support Plans and have approved any changes. After the 3 month period, the Area Director will review the documentation that guardians or Health Care Representatives are receiving updated copies of consumers BSPs a minimum of quarterly to	11/07/2012

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	approval/implementation of the restrictive program. 9-3-4(a)		ensure that these requirements continue to be met. Responsible Party: Program Director, Area Director	

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W0264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's specially constituted/HRC (Human Rights Committee) failed to ensure the clients' rights were not violated by the restriction of locking knives without due process through assessment of individual need. Findings include: Observations were conducted at the group home on 10/1/12 from 4:51 PM through 6:00 PM. At 5:10 PM staff #1 was assisting clients A, B and C with the evening meal preparation in the group home kitchen. Staff #1 exited the kitchen and entered the group home living room area where the medication cabinet was located. Staff #1 approached the medication administration area where staff #2 was preparing medication for administration and stated, "I need a knife" and removed a knife from the medication cabinet. At 5:45 PM staff #1 washed the	W0264	The Program Director will review the need for all consumers regarding restricted access to the knives in the home. If it is determined that any consumers need restricted access, the Program Director will ensure that the restriction is put into the consumers Behavior Support Plan and guardian and Human Rights Committee Approval is obtained. For other consumers that do not require restricted access to the knives in the home, the Home Manager and Program Director will develop a way for them to have access to the knives as needed such as having a key to where the knives are locked up. The Program Director will receive retraining on the need to ensure that Human Rights Committee Approvals are obtained for any restrictions recommended for any consumer prior to the restrictions being implemented. Ongoing, the Program Director	11/07/2012

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	knife at the kitchen sink and returned the knife to the medication administration cabinet. Client A's record was reviewed on 10/2/12 at 12:14 PM. Client A's ISP (Individual Support Plan) dated 8/11/11 did not indicate client A needed or required to be restricted from access and/or use of knives. Client A's record did not indicate a BSP (Behavior Support Plan). Client A's CFA (Comprehensive Functional Assessment) dated 7/27/09 did not indicate the need for restricted access to knives. Client A's record failed to indicate the HRC had reviewed the facility practice of restricting access to knives without assessment, program, or guardian/surrogate approval. Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's ISP dated 3/23/12 did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's BSP dated 6/30/12 did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's CFA undated did not indicate client B needed to be restricted from access to and/or the use of knives. Client B's record failed to indicate the HRC had reviewed the facility practice of restricting access to knives without assessment, program, or		will ensure that Human Rights Committee Approvals are obtained for any restrictions recommended for any consumer prior to the restrictions being implemented. Responsible Staff: Program Director, Area Director	

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	guardian/surrogate approval. Client C's record was reviewed on 10/2/12 at 1:09 PM. Client C's ISP dated 2/7/12 did not indicate client C needed to be restricted from access to and/or the use of knives. Client C's BSP dated 9/1/12 did not indicate client C needed to be restricted from access to and/or the use of knives. Client C's CFA dated 4/22/12 did not indicate client C needed to be restricted from access to and/or the use of knives. Client C's record failed to indicate the HRC had reviewed the facility practice of restricting access to knives without assessment, program, or guardian/surrogate approval. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated the group home locked the knives in the medication cabinet. QMRP #1 indicated client A, B and C did not have product misuse or history of misuse/threat of use of knives as weapons. QMRP #1 indicated client A, B and C did not have a key to access the knives in the house. QMRP #1 indicated locking the knives was a rights restriction that required HRC approval. 9-3-4(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 2 of 3 sampled clients (B and C), the facility nursing services failed to develop a fall prevention protocol for client B. The facility's nursing services failed to ensure clients B and C had recommended adaptive equipment. Findings include: 1. Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's Quarterly Nursing Assessment indicated the following: -3/30/11 note indicated, "abnormal gait" with fall at work reported. -6/7/11 note indicated, "abnormal gait." -9/13/11 note indicated, "abnormal gait." -12/1/11 note indicated, "abnormal gait" with one fall reported. -3/13/12 note indicated one fall reported while in the shower due to an, "abnormal gait." -6/11/12 noted indicated client B had two falls this quarter and was receiving	W0331	1. Client B Fall Risk Protocol has been completed. The Program Nurse will be retrained on ensuring that protocols are developed as needed based on consumers risk and needs. Ongoing, the Program Nurse will ensure that protocols are developed as needed based on consumers documented risks and needs. Program Nurse will ensure that all staff are trained on any protocols that are developed based on consumers risks and needs. 2. Training goals have been developed for Client B to prompt her to wear her eyeglasses and use her walker. All Direct Support Staff will receive training on implementing Client B's training goals for her adaptive equipment. Program nurse will follow up on the recommendation for Client C for use of a Occlusal Mouthguard and Rigid Orthotics for her feet. Program nurse will ensure this adaptive equipment has been obtained and staff are trained on the use of this adaptive equipment. The Program Director will receive retraining to include the need to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. Ongoing, the Program Director	11/07/2012

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	physical therapy for strength, flexibility and balance. -9/11/12 note indicated, "... had falls this past month. Roller walker ordered and delivered today." Client B's Medical Appointment form dated 5/9/12 indicated, "Evaluate and treat for a small fracture lower spine, scoliosis, frequent falls and pain management. Seen for PT (Physical Therapy) evaluation regarding low back pain and gait abnormality." 2. Observations were conducted at the group home on 10/1/12 from 4:51 PM through 6:00 PM. Client B and client C were observed in the home throughout the observation period. Client B did not utilize a rolling walker, wear eyeglasses or hearing aids during the observation period. Client C did not utilize a mouth guard or foot orthotic device. Observations were conducted at the group home on 10/2/12 from 6:00 AM through 8:00 AM. Client B and client C were observed in the home throughout the observation period. Client B did not utilize a rolling walker, wear eyeglasses or hearing aids during the observation period. Client C did not utilize a mouth guard or foot orthotic device.		will ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. Responsible Party: Program Nurse, Nursing Supervisor , Program Director, Area Director	

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	15G466	A. BUILDING 00 B. WING	10/08/2012

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	Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's vision medical appointment form dated 6/8/11 indicated the recommendation for full time prescription use. Client B's hearing appointment form dated 3/22/11 indicated the recommendation for full time use of hearing aids. Client B's dental examination form dated 2/27/12 indicated the recommendation for use of a bite guard. Client B's Quarterly Nursing Assessment dated 9/11/12 indicated client B had an PCP (Primary Care Physician)prescription order for a rolling walker. Client B's Quarterly Nursing assessment dated 9/11/12 indicated client B had received the rolling walker for full time use. Client B's ISP (Individual Support Plan) dated 3/23/12 did not indicate formal/informal training or supports to assist client B to use eyeglasses, hearing aids or the rolling walker. Client C's record was reviewed on 10/2/12 at 1:09 PM. Client C's physicians order form dated 8/27/12 indicated the use of Rigid Orthotic daily (plantar fasciitis) and Occlusal Mouthguard (TMJ/Temporomandibular Joint Disorder). Client C's Monthly Health Care Coordination form dated August 2012 indicated client C should be using a			

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	mouthguard and have orthotics for her feet. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated client B's guardian had concerns regarding her ambulation and requested the walker. QMRP #1 stated, "... [client B] sometimes has issues with balance." When asked if client B had a history of falls, QMRP #1 stated, "[Client B] has had a few, two or three since I've been here. I've been here a couple of months." QMRP #1 indicated client B did not have a fall risk prevention plan. QMRP #1 indicated client B should wear eyeglasses, hearing aids and use her rolling walker. QMRP #1 indicated client B refused to wear her eyeglasses and use her walker. QMRP #1 indicated client B's hearing aids were being adjusted due to not fitting properly and falling out. QMRP #1 indicated client B did not have a formal goal to train/assist her to use her eyeglasses or walker. QMRP #1 indicated client B did not have a mouthguard. QMRP #1 indicated client C did not have a mouthguard or orthotics for her feet. Interview with nurse #1 on 10/3/12 at 10:30 AM indicated client B had a history of falls. Nurse #1 indicated client B's PCP (Primary Care Physician) had written a			

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	prescription for client B to use a rolling walker while ambulating. Nurse #1 indicated client B needed a falls risk plan. 9-3-6(a)			

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W0356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 2 of 3 sampled clients (A and B), the facility failed to ensure client A received timely recommended dental treatment. The facility failed to ensure client B attended scheduled dental appointments. Findings include: 1. Client A's record was reviewed on 10/2/12 at 12:14 PM. Client A's 2/20/12 dental appointment form indicated the recommendation for a root canal and permanent crown replacement. Client A's 5/16/12 and 8/29/12 dental appointment form indicated the recommendation for a root canal and permanent crown replacement. Client A's Health Care Coordination Monthly review for August 2012 indicated, "[Dentist] re-recommend(s) root canal. Reminded them several (sic) request for Medicaid denial." Client A's Health Care Coordination Monthly review for August 2012 indicated the facility nurse had delivered client A's X-rays to a new dentist. Client A's Health Care Coordination Monthly review for August	W0356	1. Home Manager, Program Director and Program Nurse will be retrained on the need to follow up to ensure all clients are receiving dental treatment as recommended. They will also be retrained that if there are issues with a dentist getting paperwork to submit for dental services not paid through Medicaid they are to notify the Area Director to secure payment so that clients can receive services they need in a timely manner. Area Director will work with Program Nurse to determine what paperwork is needed to submit for payment for Client A's recommended dental treatment. 1.Al l Direct Care staff and Home Manager will receive retraining on the need to ensure consumers medical and dental appointments are kept as scheduled. If an appointment has to be cancelled for any reason, Direct care staff will notify the Home Manager and Program Nurse as to the reason the appointment was missed or rescheduled so they can follow up to ensure all necessary appointments are completed.	11/07/2012

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	2012 indicated the root canal was scheduled for 8/13/12 but dentist refused to complete the root canal without payment up front due to Medicaid refusal to cover the costs. 2. Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's June 2012 Nursing Progress notes indicated, "Dentist called stating, [Client B] did not show for scheduled appointment today and that this was the third or fourth time missed." Client B's July 2012 Nursing Progress Notes indicated, "[Dentist], called to report [client B] missed her dental appointment today, stated [client B] has missed three in a row and dentist refuses to treat [client B] in the future." Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated client A had a 2/20/12 recommendation for a root canal and crown replacement. Interview with nurse #1 on 10/3/12 at 10:30 AM indicated client B had a 2/20/12 recommendation for a root canal and crown replacement. Nurse #1 indicated the dentist had not completed the paperwork needed for the facility to issue a check for payment. Nurse #1 indicated client A should have had the recommended services prior to the 10/3/12 review. Nurse #1 indicated client B had missed dental appointments and was scheduled to start services with a new dentist. 9-3-6(a)		Ongoing, the Program Nurse and Home Manager will ensure that there is follow up with medical professionals to obtain paperwork when recommended services are not covered by Medicaid. If responses are not received from the medical professionals, the HM and Program Nurse will consult with the Area Director to work out a plan so recommended services are paid so that consumers can receive recommended treatment. Ongoing, the Program Nurse and Home Manager will meet a minimum of monthly to review all consumer medical/dental appointments scheduled for the following month. Home manager and Program Nurse will work together to ensure all appointments are being completed or rescheduled as needed. If there are ongoing issues with a particular consumer not keeping the medical appointments, the Program Nurse and Home Manager will consult with the Program Director to determine if the issues are a result of client refusals, etc. or staff not keeping appointments. If the issues are a result of client refusals the IDT team will meet to problem solve how to ensure the consumer is getting to appointments. If the issues are a result of staff not keeping appointments, the Program	

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			Director will evaluate if corrective action for staff is necessary. Responsible Party: Home Manager, Program Director, Area Director, Program Nurse	

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W0369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure staff administered medication as ordered for 8 missed of 31 medication doses. Findings include: Observations were conducted at the group home on 10/2/12 from 6:00 AM through 8:00 AM. At 7:11 AM client B was prompted by staff #3 to come to the medication administration area to receive her morning medications. Client B received 1 Ranitidine (ulcers) tablet 150 milligram, 1 Lithium Carbonate (bipolar) 300 milligrams, 1 Gabapentin (seizures) tablet 600 milligrams, 1 Oyster Shell Calcium (supplement) tablet 500 milligrams, 1 Thera (supplement) tablet, 1 Levetiracetam (seizures) tablet 100 milligrams, 1 Fluvoxamine (obsessive compulsive disorder) capsule 40 milligrams, Cholestyramine Powder (cholesterol) 4 grams, Denta 5000 cream toothpaste (oral health), Elidel cream 1% (topical) and Ketoconazole cream 2% (topical).	W0369	All staff will receive retraining on all consumers medication orders including Client B Cholestyramaniene powder needing to be given 1 hour after all other medications. Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are following all consumers medication orders as written. Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are following all consumers medication orders as written. Responsible staff: Home Manager, Program Director	11/07/2012

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	Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's MAR (Medication Administration Record) dated 10/1/12 through 10/31/12 indicated, "Cholestyramine powder 4 gram lite give 1/2 scoop daily... at 8:00 AM." Client B's Pharmacy Consulting Form dated 2/13/12 note to nursing indicated, " please note: Cholestyramine powder should be administered separate from other medications due to the possible interference of absorption of medications and thus making them less effective. All other medication should be taken one hour before or 4-6 hours after cholestyraramine. Recommend making an adjustment to the current administration time (7 am) to be given one hour after other 7 am scheduled medications. Cholestyramine changed to 8 am on 3/1/12." Interview with nurse #1 on 10/3/12 at 10:30 AM indicated client B's Cholestyramine powder should not be administered with other medications. Nurse #1 indicated client B's Cholestyramine powder should be administered one hour prior to other medications or 4 to 6 hours other medications. 9-3-6(a)			

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W0382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3 sampled clients (A, B and C) plus 3 additional clients (D, E and F), the facility failed to ensure medications were maintained in a secure location during the medication administration process. Findings include: Observations were conducted at the group home on 10/2/12 from 6:00 AM through 8:00 AM. At 7:23 AM staff #3 exited the medication administration area with client B to brush her teeth. Staff #3 did not lock the medication cabinet where clients A, B, C, D, E and F's medications were stored. At 7:25 AM client C entered the medication administration area with no staff. At 7:43 AM staff #3 exited the medication administration area to get client E from the kitchen for her morning medication. Staff #3 did not lock the medication cabinet when she exited the medication administration area. Interview with staff #3 on 10/2/12 at 7:23 AM indicated the medication administration cabinet should be locked when staff are not in the area.	W0382	All staff will receive retraining on ensuring that the medication cabinet is locked during medication administration when exiting the medication area for any reason. Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are locking the medication cabinet during medication administration when staff are out of the area for any reason. Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are locking the medication cabinet during medication administration when staff are out of the area for any reason.	11/07/2012

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	Interview with nurse #1 on 10/3/12 at 10:30 AM indicated the medication administration cabinet contained the medications for clients A, B, C, D, E and F. Nurse #1 indicated the medication cabinet should not be left unlocked without staff present in the area. 9-3-6(a)			

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 2 of 3 sampled clients with adaptive equipment (B and C), the facility failed to ensure client B utilized a rolling walker, eyeglasses and hearing aids while in the group home. The facility failed to ensure client C had and utilized a mouth guard and foot orthotic device. Findings include: Observations were conducted at the group home on 10/1/12 from 4:51 PM through 6:00 PM. Client B and client C were observed in the home throughout the observation period. Client B did not utilize a rolling walker, wear eyeglasses or hearing aids during the observation period. Client C did not utilize a mouth guard or foot orthotic device. Observations were conducted at the group home on 10/2/12 from 6:00 AM through 8:00 AM. Client B and client C were observed in the home throughout the observation period. Client B did not utilize a rolling walker, wear eyeglasses	W0436	Training goals have been developed for Client B to prompt her to wear her eyeglasses and use her walker. All Direct Support Staff will receive training on implementing Client B's training goals for her adaptive equipment. Program nurse will follow up on the recommendation for Client C for use of a Occlusal Mouth guard and Rigid Orthotics for her feet. Program nurse will ensure this adaptive equipment has been obtained and staff are trained on the use of this adaptive equipment. The Program Director will receive retraining to include the need to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. Ongoing, the Program Director will ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. The Area Director will review the next 3	11/07/2012

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	or hearing aids during the observation period. Client C did not utilize a mouth guard or foot orthotic device. Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's vision medical appointment form 6/8/11 indicated the recommendation for full time prescription use. Client B's hearing appointment form 3/22/11 indicated the recommendation for full time use of hearing aids. Client B's dental examination form dated 2/27/12 indicated the recommendation for use of a bite guard. Client B's Quarterly Nursing Assessment dated 9/11/12 indicated client B had an PCP (Primary Care Physician) prescription order for a rolling walker. Client B's Quarterly Nursing assessment dated 9/11/12 indicated client B had received the rolling walker for full time use. Client B's ISP (Individual Support Plan) dated 3/23/12 did not indicate formal/informal training or supports to assist client B with the use of eyeglasses, hearing aids or the rolling walker. Client C's record was reviewed on 10/2/12 at 1:09 PM. Client C's physicians order form dated 8/27/12 indicated the use of Rigid Orthotic daily (plantar fasciitis) and Occlusal Mouthguard for TMJ (Temporomandibular Joint Disorder). Client C's Monthly Health		ISPs submitted by this Program Director to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. Responsible Party: Program Nurse, Nursing Supervisor, Program Director, Area Director	

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	Care Coordination form dated August 2012 indicated client C should be using a mouthguard and have orthotics for her feet. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated client B should wear eyeglasses, hearing aids and use her rolling walker. QMRP #1 indicated client B refused to wear her eyeglasses and use her walker. QMRP #1 indicated client B's hearing aids were being adjusted due to not fitting properly and falling out. QMRP #1 indicated client B did not have a formal goal to assist/train her to use her eyeglasses or walker. QMRP #1 indicated client B did not have a mouthguard. QMRP #1 indicated client C did not have a mouthguard or orthotics for her feet. 9-3-7(a)			

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W0440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (A, B and C) plus 3 additional clients (D, E and F), the facility failed to hold evacuation drills for each quarter on each shift of personnel. Findings include: The facility's evacuation drills were reviewed on 10/2/12 at 10:03 AM. The review indicated the facility failed to conduct evacuation drills for 6 of 6 clients (A, B, C, D, E and F) living in the group home for the first quarter, January 2012 through March 2012 for the 11:00 PM through 7:00 AM shift. The facility failed to conduct evacuation drills for the second quarter, April 2012 through June 2012 for the 7:00 AM through 3:00 PM shift. The facility failed to conduct evacuation drills for the third quarter, July 2012 through September 2012 for the 3:00 PM through 11:00 PM shift. Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated evacuation drills should be conducted quarterly on each shift of personnel. 9-3-7(a)	W0440	All Direct Support Professionals will receive a retraining at least every other month to ensure that they understand the importance of completing the monthly fire drills. The training will include reviewing a copy of the fire drill schedule. Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, the completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill. Responsible Staff: Home Manager, Program Director, Quality Assurance	11/07/2012

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	15G466	A. BUILDING 00 B. WING	10/08/2012

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W0455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 2 of 3 sampled clients (B and C) plus 1 additional client (D), the facility failed to ensure clients washed or sanitized their hands prior to or during medication administration. Findings include: Observations were conducted at the group home on 10/2/12 from 6:00 AM through 8:00 AM. At 7:11 AM client B was prompted by staff #3 to come to the medication administration area. Client B came to the medication administration area and sat down. Staff #3 proceeded to administer client B's morning medications. Staff #3 did not prompt or encourage client B to wash or sanitize her hands prior to handling her medication. At 7:29 AM client C was prompted by staff #3 to come to the medication administration area. Client C came to the medication administration area and sat down. Staff #3 proceeded to administer client C's morning medications. Staff #3 did not prompt or encourage client C to wash or sanitization her hands prior to handling her medication.	W0455	All Direct Care staff will receive retraining on ensuring that all consumers wash or use hand sanitizer on their hands prior to receiving their medications to prevent spread of infection. Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are ensuring that consumers are washing or using hand sanitizer on their hands prior to receiving their medications. Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are ensuring that consumers are washing or using hand sanitizer on their hands prior to receiving their medications. Responsible Party: Home Manager, Program Director	11/07/2012

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	Interview with nurse #1 on 10/3/12 at 10:30 AM indicated clients should wash or sanitize their hands prior to medication administration. 9-3-7(a)			

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W9999	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met. 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division. This rule was not met as evidenced by: Based on record review and interview for 2 of 17 allegations of abuse, mistreatment or neglect reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) within 24 hours regarding an incident of medication omission regarding client B. The facility failed to immediately notify BDDS regarding an incident of clients D, E and F's missing petty cash. Findings include: The facility's BDDS reports and investigations were reviewed on 10/2/12 at 8:50 AM. The review indicated the following: -BDDS follow up report dated 8/31/12 indicated, "[client B] missed the following	W9999	All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to	11/07/2012

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	medications: Oyster Shell Calcium with Vitamin D 500 milligrams (supplement) and Risperidone 1 milligram (impulse control)." The BDDS report indicated, "The on call nurse was contacted by staff, [staff #1], on 8/24/12 at 5:15 PM regarding the medication error. [Staff #1] noticed the error (medication was still in the cabinet but [staff #2] had signed off that he medication was given). On-call nurse informed the house nurse on 8/27/12. This home is in between home managers and although one home manage is helping cover the home the 6 day difference is due to a miscommunication. Program director was not made aware of the error and able to get clarification until 8/29/12 and made the report right away." -BDDS report dated 9/11/12 indicated, "Money was given to staff on the evening of 9/7/12 and put in a lock box. Later that evening staff took some of the consumers to the gas station. The next morning when staff went to take the consumers out [client D] was missing $5.00..., [client E] was missing $5.00 and [client F] was missing $5.00." Interview with AS (Administrative Staff) #2 on 10/2/12 at 11:14 AM indicated BDDS reportable incidents included medication omissions and clients' missing petty cash funds. AS #2 indicated BDDS reportable incidents should be reported to BDDS within 24 hours of the date of the incident. 9-3-1(b)		ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. Responsible Party: Home Manager, Program Director, Area Director	

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